15 Month Visit

NAME DATE

Are you concerned about your child's…..

1. Nutrition or eating habits?	YES	NO
2. Bowel movements?	YES	NO
3. Skin color or rashes?	YES	NO
4. Overall development?	YES	NO
5. Sleep habits?	YES	NO

Does your child……

1. Listen to a story?	YES	NO
2. Imitate activities?	YES	NO
3. Indicate wants by pulling, pointing or grunting?	YES	NO
4. Bring objects to show you?	YES	NO
5. Hand you a book when he/she wants a story?	YES	NO
6. Say 2 to 3 words (other than Mama or Dada) with meaning?	YES	NO
7. Follow simple commands?	YES	NO
8. Scribble?	YES	NO
9. Walk then stoop and recover?	YES	NO
10. Take steps backward?	YES	NO
11. Drink from a cup	YES	NO
12. Put a block in a cup?	YES	NO
13. Point to one ore more body parts?	YES	NO
14. Brush teeth?	YES	NO
15. Ride in a rear facing car seat?	YES	NO
16. Do you have Poison Controls number posted? (1-800-222-1222)	YES	NO
17. Do you have functioning smoke detectors?	YES	NO
18. Do you have poisons and toxic household products stored safely?	YES	NO

Tuberculosis Screen (TB)

1. Has a family member or contact had tuberculosis disease?	YES	NO
2. Has a family member had a positive TB test?	YES	NO
3. Was your child born outside the US, Canada, Australia, New Zealand or Western Europe?	YES	NO
4. Has your child traveled to a high risk country for more than 1 week?	YES	NO

LEAD Screen (Pb)

1. Does your child live in or regularly visit a house built before 1950?	YES	NO
2. Does your child live in or visit a house built before 1978 with recent remodeling or renovation? (with in 6 months)	YES	NO
3. Have a sibling or playmate who now or did have lead poisoning?	YES	NO

over

Do you have any other concerns you wish to discuss? YES NO

Office use only

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